Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective April 1, 2012

Prior Authorization Forms: available online at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132

The PDL applies to Medicaid fee-for-service clients. It does not apply to clients enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ALZHEIMER'S AGENTS *Effective 4/1/2012*	**No Prior Authorization Required (*Must meet eligibility criteria)** Aricept (5mg and 10mg) Aricept ODT 5mg,10mg generic donepezil tab donepezil ODT generic galantamine and galantamine ER NAMENDA	**Prior Authorization Required** COGNEX EXELON (cap, soln. and patch) RAZADYNE ARICEPT 23mg	***eligibility criteria for Preferred Agents –** All preferred agents will be approved without prior authorization if the client has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the client has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Clients currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia. Preferred agents will be approved if the client has a diagnosis of dementia.
ANTIEMETICS *Effective 1/1/2012*	**No Prior Authorization Required** ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 6 years only) ZOFRAN tablets	**Prior Authorization Required** ANZEMET EMEND KYTRIL SANCUSO ALOXI ZOFRAN suspension ZOFRAN ODT ZUPLENZ	Non-preferred products will be approved for clients who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Ondansetron suspension will be approved for clients 6 and over with a feeding tube. Emend will be approved upon verification that the client is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.**

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ANTIDEPRESSANTS **Newer Generation Antidepressants** *Effective 1/1/2012*	**No Prior Authorization Required** Bupropion IR, SR, XL citalopram fluoxetine fluvoxamine mirtazipine nefazodone paroxetine sertraline venlafaxine IR, ER tabs venlafaxine XR capsules EFFEXOR IR, XR	**Prior Authorization Required** APLENZIN ER (bupropion ER) CYMBALTA (duloxetine) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) PRISTIQ (desvenlafaxine) PEXEVA (paroxetine) paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine) VIIBRYD	Non-preferred products will be approved for clients who have failed treatment with two Preferred Products with exceptions for Cymbalta and Lexapro (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Clients currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** Cymbalta: Clients will not need to fail on two Preferred Products if the diagnosis is Fibromyalgia or Diabetic Peripheral Neuropathic Pain. Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses. Cymbalta will be approved for individuals with chronic musculoskeletal pain related to osteoarthritis or chronic lower back pain, who have taken at least a 3 month trial of narcotic therapy. Lexapro: Clients will not need to fail on two Preferred Products if they are under 18 years of age and have failed therapy with fluoxetine. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Clients currently stabilized on Lexapro will be eligible for grandfathering for one year. **Verification may be provided from the prescriber or the pharmacy.**
ANTIHISTAMINES **Newer Generation Antihistamines** *Effective 7/1/2011*	**No Prior Authorization Required** loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)	**Prior Authorization Required** ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine (generic Allegra) levocetirizine XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand	Non-preferred antihistamines will be approved for clients who have failed treatment with two preferred products in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Antihistamine/Decongestant Combinations *Effective 7/1/2011*	**No Prior Authorization Required**	**Prior Authorization Required** ALLEGRA-D (fexofenadine-D) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	Non-preferred antihistamine/decongestant combinations will be approved for clients who have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis not controlled with nasal steroids alone. .

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ANTIHYPERTENSIVES **Angiotensin Receptor Blockers (ARBs)** *Effective 7/1/2011*	**No Prior Authorization Required** AVAPRO (irbesartan) DIOVAN (valsartan) losartan	**Prior Authorization Required** ATACAND (candesartan) BENICAR (olmesartan) COZAAR (losartan) EDARBI (azilsartan) MICARDIS (telmisartan) TEVETEN (eprosartan)	Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for clients who have failed treatment with two preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.).
ARB Combinations *Effective 7/1/2011*	**No Prior Authorization Required** DIOVAN-HCT (valsartan/HCTZ) AVALIDE (irbesartan/HCTZ) losartan/HCTZ	**Prior Authorization Required** ATACAND-HCT (candesartan/HCTZ) AZOR(amlodipine/olmesartan) BENICAR-HCT (olmesartan/HCTZ) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz) HYZAAR HCT BRAND MICARDIS-HCT (telmisartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan)	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/2011*	**No Prior Authorization Required**	**Prior Authorization Required** AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	

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<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td>ANTIPLATELETS

Effective 1/1/2012</td><td>AGGRENOX (ASA/dipyridamole)
EFFIENT (prasugrel)
PLAVIX (clopidogrel)
Ticlopidine</td><td>BRILINTA (tigacrelor)</td><td>EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg.

BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg or age ≥ 75 years) OR who have had a hypersensitivity reaction to clopidogrel or prasugrel AND must be taking a maintenance dose of aspirin not exceeding 100 mg/day.

Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.</td></tr>
<tr><td>ATYPICAL ANTIPSYCHOTICS (oral)

Effective 4/1/2012</td><td>No Prior Authorization Required
ABILIFY
clozapine
CLOZARIL
GEODON
olanzapine
risperidone
RISPERDAL
SAPHRIS
SEROQUEL IR*
ZYPREXA</td><td>Prior Authorization Required
FANAPT
FAZACLO
INVEGA
LATUDA
SEROQUEL XR
ZYPREXA ZYDIS
* for injectable Atypical Antipsychotics please see Appendix P for criteria</td><td>*Seroquel IR when given at subtherapeutic doses may be restricted for therapy exceeding 30 days. See Appendix P for more details.
Non-preferred products will only be approved for their FDA approved indications and age limits and only if the client has failed on three preferred products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions).
• Age Limits: All products including preferred products will require a prior authorization for clients under 5 years of age. Clients under 5 years of age who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering.
▪ New Atypical Antipsychotic prescriptions for clients under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. Prior authorization approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber.
▪ Clients under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.
• Grandfathering: Clients currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the client does not meet the age, dosing or FDA approved indication requirements. Verification may be provided from the prescriber or the pharmacy.
• Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the client must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen.
<table>
<tr><th>Brand Name</th><th>Generic Name</th><th>Quantity Limits</th></tr>
<tr><td>Abilify</td><td>aripiprazole</td><td>Maximum one tablet per day</td></tr>
<tr><td></td><td>clozapine</td><td>Maximum dosage of 900mg per day</td></tr>
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

Clozaril	**clozapine**	**Maximum dosage of 900mg per day**
Fazaclo	**clozapine**	**Maximum dosage of 900mg per day**
Fanapt	**iloperidone**	**Maximum two tablets per day**
Geodon	**ziprasidone**	**Maximum two tablets per day**
Invega	**paliperidone**	**Maximum one tablet per day**
Latuda	**lurasidone**	**Maximum one tablet per day**
Risperdal	**risperidone**	**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**
	risperidone	**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**
Saphris	**asenapine**	**Maximum two tablets per day**
Seroquel	**quetiapine**	**Maximum three tablets per day**
Seroquel XR	**quetiapine XR**	**Maximum one tablet per day except 300mg and 400mg tablets will be approved for up to 2 tablets per day**
Zyprexa	**olanzapine**	**Maximum one tablet per day**

INDICATIONS

- Fanapt - Acute treatment of schizophrenia in adults
- Fazaclo
  - Treatment-Resistant Schizophrenia
  - Reducing the Risk of Recurrent Suicidal Behavior in Patients with Schizophrenia or Schizoaffective Disorder
- Invega
  - acute and maintenance treatment of schizophrenia
  - acute treatment of schizoaffective disorder as monotherapy
  - acute treatment of schizoaffective disorder as an adjunct to mood stabilizers and/or antidepressants
- Latuda - Treatment of schizophrenia
- Seroquel XR
  - Treatment of schizophrenia
  - Acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex
  - Acute treatment of depressive episodes associated with

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			bipolar I disorder ➢ Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex ➢ Adjunctive treatment of major depressive disorder (MDD) ▪ Zyprexa Zydis ➢ Schizophrenia ➢ Bipolar I Disorder (Manic or Mixed Episodes) Fanapt will be approved for the treatment of schizophrenia if the client is 18 years of age or older and has tried and failed treatment with three preferred products in the last 5 years. A maximum of two tablets per day will be approved. Fazaclo will be approved for the treatment of schizophrenia if the client is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years. Invega will be approved for the treatment of schizophrenia or schizoaffective disorder if the client is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved. Latuda will be approved for the treatment of schizophrenia if the client is 18 years of age or older and has tried and failed treatment with three preferred products in the last 5 years. A maximium of one tablet per day will be approved. Latuda will be approved without failed treatment for the treatment of newly diagnosed schizophrenia in female clients that are pregnant. A maximum of one tablet per day will be approved. Seroquel XR will be approved if the client is 18 years of age or older, has tried and failed treatment with three preferred products in the last five years and is being treated for one of the following indications: ▪ Schizophrenia ▪ Acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex ▪ Acute treatment of depressive episodes associated with bipolar I disorder ▪ Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex ▪ Adjunctive treatment of major depressive disorder (MDD) If a client has been stabilized on Seroquel for at least 30 days with a positive

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			response but is unable to tolerate the side effects, Seroquel XR may be approved without failure of two additional agents. *Please see quantity limit table for limitations.* Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 disorder if the client is 13 years of age or older and has tried and failed treatment with three preferred products (one of which must be an olanzapine tablet) in the last 5 years. A maximum of one tablet per day will be approved. For clients that are stabilized on Zyprexa tablets with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month will be allowed without three product failures.
BISPHOSPHONATES (oral) *Effective 10/1/2011*	**No Prior Authorization Required** alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets	**Prior Authorization Required** ACTONEL ACTONEL w/Calcium BONIVA FOSAMAX (brand) FOSAMAX plus D Etidronate	Non-preferred products will be approved for clients who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Prior authorization will be approved for alendronate oral solution for clients with documented difficulty swallowing without treatment failure. Prior authorization will be approved for etidronate in clients with heterotopic ossification without treatment failure.
DIABETES MANAGEMENT CLASSES (oral) **Biguanides** *Effective 10/1/2011*	**No Prior Authorization Required** metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets	**Prior Authorization Required** FORTAMET GLUCOPHAGE (brand) GLUCOPHAGE XR (brand) GLUMETZA metformin ER 750mg RIOMET 500mg/5ml	Non-preferred products will be approved for clients who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for clients who meet one of the following: ➢ under the age of 12 ➢ with a feeding tube ➢ who have difficulty swallowing
Hypoglycemic Combinations *Effective 10/1/2011*	**No Prior Authorization Required** glyburide/metformin* JANUMET* (sitagliptin/metformin) KOMBIGLYZE* (saxaglipin/metformin)	**Prior Authorization Required** ACTOPLUS MET AVANDAMET AVANDARYL DUETACT glipizide/metformin GLUCOVANCE (brand) METAGLIP PRANDIMET	Non-preferred products will be approved for clients who have been stable on the two individual ingredients for 3 months and have an adherence issue. *Approval for selected preferred products require a prior therapeutic trial with metformin and must follow FDA approved dosing
Meglitinides *Effective 10/1/2011*	**No Prior Authorization Required**	**Prior Authorization Required** PRANDIN STARLIX	Non-preferred products will be approved for clients who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Newer Diabetic Agents	**no prior authorization required**	**Prior Authorization Required** SYMLIN (pramlintide)	* Approval for selected preferred products require a trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

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Effective 10/1/2011	*BYETTA (exenatide) *JANUVIA (sitagliptin) *ONGLYZA (saxagliptin) *TRADJENTA (linagliptin)	VICTOZA (liraglutide)	**For all products**, dosing will be limited to FDA approved dosing. Prior Authorization will be required for doses in excess of FDA approved dosing. Non-preferred products will be approved for clients who have failed treatment with one preferred product in the last year. Prior authorization will be approved for Symlin products for clients with Diabetes Mellitus Type 1 without failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Thiazolidinediones *Effective 10/1/2011*	**No Prior Authorization Required** ACTOS (pioglitazone)	**Prior Authorization Required** AVANDIA (rosiglitazone)	Non-preferred products will be approved for clients who have failed treatment with ACTOS in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) ***Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy.**
ERYTHROPOIESIS STIMULATING AGENTS *Effective 10/1/2011*	***Must meet eligibility criteria** PROCRIT	**Prior Authorization Required** ARANESP EPOGEN	***Eligibility Criteria for all agents in the class** Clients must meet all criteria in one of the following four areas: ➢ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. ➢ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL ➢ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). ➢ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. Hemoglobin results must be from the last 30 days. Medication must be administered in the client's home or long-term care facility. (CONTINUED) **Non-preferred products:** ➢ Same as above; **and** ➢ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoeisis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer indications, the distribution of a medication guide to the patient is the only requirement currently.**

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GROWTH HORMONES *Effective 4/1/2012*	**No Prior Authorization Required** NORDITROPIN OMNITROPE SAIZEN	**Prior Authorization Required** GENOTROPIN HUMATROPE NUTROPIN SEROSTIM TEV-TROPIN ZORBTIVE	Non-preferred Growth Hormones will be approved if **both** of the following criteria are met: ▪ Client failed treatment with two preferred products within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Client has a qualifying diagnosis: ➢ Prader-Willi ➢ Chronic renal insufficiency/failure ➢ Turner's Syndrome ➢ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma ➢ Wasting associated with AIDS or cachexia ➢ Noonan Syndrome
INTRANASAL CORTICOSTEROIDS *Effective 4/1/2012*	**No Prior Authorization Required** fluticasone (generic FLONASE) NASACORT AQ	**Prior Authorization Required** BECONASE AQ FLONASE NASAREL NASONEX OMNARIS RHINOCORT AQ VERAMYST	Non-preferred Intranasal Corticosteroids will be approved if the client has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). ★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products. ★Brand name Flonase will require a letter of medical necessity
LEUKOTRIENE MODIFIERS *Effective 4/1/2012*	**No Prior Authorization Required** SINGULAIR (montelukast)	**Prior Authorization Required** ACCOLATE (zafirlukast) ZYFLO (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: ▪ Client failed treatment with Singulair in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Client has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS *Effective 4/1/2012*	**No Prior Authorization Required** AVONEX BETASERON REBIF COPAXONE	**Prior Authorization Required** AMPYRA EXTAVIA GILENYA	Non-preferred Interferon products will be approved if the client has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). **Gilenya** will be approved if the client has failed treatment with one interferon and Copaxone. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). **Ampyra** – A 30 day supply of Ampyra will be approved if all of the following criteria are met: • Client has a diagnosis of MS; • Client is ambulatory and has established a baseline Timed 25-foot Walk (T25FW) assessment; • Client is currently receiving a disease modifying agent (if indicated); • Client has no history of seizure disorder; • Client has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min);

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			• Prescriber is a neurologist or is consulting a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (up to one year) will be approved if documentation shows improvement in ambulation (measured by T25FW assessment).
OPHTHALMIC ALLERGY *Effective 4/1/2012*	**No Prior Authorization Required** cromolyn PATANOL PATADAY ZADITOR	**Prior Authorization Required** ALAMAST, ALAWAY ALOCRIL, ALOMIDE BEPREVE, ELESTAT EMADINE, OPTIVAR	Non-preferred Ophthalmic Allergy medications will be approved if the client has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)
OPIOIDS **Long Acting – Oral Opioids** *Effective 7/1/2011*	**FIRST LINE (No Prior Authorization Required)** methadone (generic Dolophine) morphine ER (generic MS Contin) **SECOND LINE (see PA Criteria)** ***Fentanyl patches**	**Prior Authorization Required** AVINZA (morphine ER) BUTRANS (buprenorphine) DOLOPHINE (methadone) - Brand KADIAN (morphine ER) MS CONTIN (morphine ER) - Brand ORAMORPH SR (morphine ER) - Brand OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER) EMBEDA(morphine/naltrex.)	***Fentanyl patches are considered second line and will require failure with one oral First Line agent in the last six months** Non-preferred, long-acting oral opioids will be approved for clients who have failed treatment with two 1st or 2nd line preferred agents in the last six months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Oxycontin and Opana ER will only be approved for twice daily dosing. **<u>Grandfathering</u>** Clients who are currently stabilized on a non-preferred, long-acting opioid may be approved to continue therapy with that agent.
OVERACTIVE BLADDER AGENTS *Effective 10/1/2011*	**No Prior Authorization Required** oxybutynin tablets (generic) oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	**Prior Authorization Required** DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) oxybutynin DITROPAN XL (brand) oxybutynin ER ENABLEX (darifenacin) flavoxate GELNIQUE (oxbutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) VESICARE (solifenacin)	Non-preferred products will be approved for clients who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.). Clients with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.

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PROTON PUMP INHIBITORS *Effective 1/1/2012*	**No Prior Authorization Required** ACIPHEX (rabeprazole) lansoprazole 15mg OTC (currently available as PREVACID 24HR) NEXIUM (esomeprazole) **packets** omeprazole generic capsules PREVACID solutab **brand** (lansoprazole) (for clients under 6) PRILOSEC OTC (omeprazole)	**Prior Authorization Required** KAPIDEX (dexlansoprazole) DEXILANT (dexlansoprazole) lansoprazole capsules lansoprazole solutabs NEXIUM (esomeprazole) capsules pantoprazole PREVACID (lansoprazole) capsules & suspension PROTONIX (pantoprazole) ZEGERID (omeprazole/Na bicarbonate) PREVPAC HELIDAC	Prior authorization will be required for therapy beyond 100 days of treatment per year for all agents. PA will be approved for clients with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID therapy or Spinal Cord Injury clients with an acid reflux diagnosis. In addition, clients with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist (of at least two weeks duration) will be approved for up to one year of daily PPI therapy. Medical justification can be submitted for review. Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: ➢ Client failed treatment with two Preferred Products within the last 24 months, ➢ Client has a qualifying diagnosis, and ➢ Client has been diagnosed by an appropriate diagnostic method. **The Qualifying Diagnoses are:** Barrett's Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, Heartburn (for Prilosec OTC only), H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD **The Appropriate Diagnostic Methods are:** GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **Quantity Limits:** Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age. Prevacid Solutab will be approved for clients 6 and older with a feeding tube. Pantoprazole will be approved for clients that have clinically significant drug-drug interactions with other PPI agents.

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PULMONARY ARTERIAL HYPERTENSION THERAPIES **Phosphodiesterase Inhibitors** *Effective 1/1/2012*	***Must meet eligibility criteria** REVATIO (sildenafil) ADCIRCA (tadalafil)	**Prior Authorization Required**	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension.
Endothelin Antagonists *Effective 1/1/2012*	**No Prior Authorization Required** Letairis (ambrisentan)	**Prior Authorization Required** Tracleer (bosentan)	Non-preferred products will be approved for clients who have failed treatment with Letairis. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
Prostanoids *Effective 1/1/2012*	**No Prior Authorization Required** epoprostenol (generic) Veletri (epoprostenol)	**Prior Authorization Required** Flolan (brand) Remodulin (treprostinil) Tyvaso (treprostinil) Ventavis (iloprost)	Non-preferred products will be approved for clients who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction) **Grandfathering:** Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
RESPIRATORY INHALANTS **Inhaled Anticholinergics & Anticholinergic Combinations** *Effective 7/1/2011*	**No Prior Authorization Required** **<u>Solutions</u>** albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) **<u>Inhalers</u>** ATROVENT HFA (ipratropium) COMBIVENT (albuterol/ipratropium) SPIRIVA Handihaler (tiotropium)	**Prior Authorization Required** **<u>Solutions</u>** ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name prior authorization stating medical necessity.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists** **(short acting)** *Effective 7/1/2011*	**No Prior Authorization Required** **Solutions** albuterol (generic) solution **Inhalers** PROAIR (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	**Prior Authorization Required** **Solutions** ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. **Inhalers** ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler MAXAIR (pirbuterol) autohaler PROVENTIL (albuterol) HFA inhaler	Non-preferred, short acting beta2 agonists will be approved for clients who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists** **(long acting)** *Effective 7/1/2011*	**No Prior Authorization Required**	**Prior Authorization Required** **Solutions** BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution **Inhalers** FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler	Non-preferred, long acting beta2 agonists will be approved for clients with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for clients with moderate to very severe COPD.
RESPIRATORY INHALANTS **Inhaled Corticosteroids** *Effective 7/1/2011*	**No Prior Authorization Required** **Solutions** budesonide nebules **Inhalers** ASMANEX (mometasone) twisthaler FLOVENT (fluticasone) HFA FLOVENT diskus **50**, **100** & 250 mcg QVAR (beclomethasone) inhaler	**Prior Authorization Required** **Inhalers** AEROBID (flunisolide) inhaler ALVESCO (ciclesonide) AZMACORT (triamcinolone) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved for clients who have failed treatment with two preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) If a client is pregnant, Pulmicort flexhaler will be approved without failure on preferred products. Grandfathering: Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Corticosteroid Combinations** *Effective 7/1/2011*	**No Prior Authorization Required** ADVAIR Diskus (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol) DULERA (mometasone/formoterol)	**Prior Authorization Required** ADVAIR HFA (fluticasone/salmeterol)	Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting both of the following criteria: ➢ Client has a qualifying diagnosis of asthma or COPD; and ➢ Client cannot take preferred drug due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. **Grandfathering:** Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.
SEDATIVE- HYPNOTICS (non-benzodiazepine) *Effective 4/1/2012*	**No Prior Authorization Required** LUNESTA (eszopiclone) zaleplon zolpidem	**Prior Authorization Required** AMBIEN CR (zolpidem) AMBIEN (zolpidem) - Brand EDLUAR (zolpidem) ROZEREM (ramelteon) SONATA (zaleplon) - Brand ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for clients who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) Rozerem will be approved for clients with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent **Children:** Prior authorizations will be approved for clients 18 years of age and older. **Duplications:** Only one agent in this drug class will be approved at a time. Approval will not be granted for clients currently taking a long-acting benzodiazepine such as clonazepam or temazepam.
SKELETAL MUSCLE RELAXANTS *Effective 7/1/2011*	**No Prior Authorization Required For Clients under 75 years of age*** baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) tizanidine (generic Zanaflex)	**Prior Authorization Required** AMRIX ER (cyclobenzaprine ER) chlorzoxazone (generic Parafon Forte) DANTRIUM (dantrolene) – Brand dantrolene (generic Dantrium) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) – Brand LIORESAL (baclofen) – Brand methocarbamol (generic	***All agents in this class will require a prior authorization for clients over 75 years of age. Approval will only be given if the client has had at least a 7 day trial with an opiate. The maximum allowable approval will be for a 7 days supply. Non-preferred skeletal muscle relaxants will be approved for clients who have documented lack of efficacy with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for clients with acute, painful musculoskeletal conditions who have failed treatment with two preferred products. (CONTINUED)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		Robaxin) NORFLEX (orphenadrine) orphenadrine (generic Norflex) PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlorzoxazone) ROBAXIN (methocarbamol) – Brand SKELAXIN (metaxalone) ZANAFLEX (tizanidine) – Brand SOMA (carisoprodol), VANADOM (carisoprodol), RELA (carisoprodol)	**Tapering:** Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for clients tapering off of carisoprodol. ★A PA will only be granted for any carisoprodol product for short-term use or tapering.
STATINS & STATIN COMBINATIONS *Effective 4/1/2012*	**No Prior Authorization Required** CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol) simvastatin* (generic Zocor)	**Prior Authorization Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin) **Statin Combinations** ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvas.)	Non-preferred Statin/Statin combinations will be approved if the client has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Children:** Altoprev, Advicor, Livalo and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for clients 10 years of age and older. Simvastatin 80mg dose products will only be covered for clients who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in clients who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.
STIMULANTS and ADHD *Effective 10/1/2011*	**No Prior Authorization Required** **(as long as age limitations are met)** mixed-amphetamine salts (generic Adderall) ADDERALL XR (brand name mixed amphetamine salts ER)	**Prior Authorization Required** ADDERALL (brand name mixed amphetamine salts) mixed-amphetamine salts ER (generic for Adderall XR) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine)	Non-preferred agents will be approved for clients who have documented failure with two Preferred products in the last 12 months (age six years or older) or documented failure with one Preferred products in the last 12 months if ages 3 – 5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.); however, certain exceptions exist for Daytrana, Intuniv, Methylin solution, Nuvigil and Provigil. Please see the criteria below. **In addition:** Non-preferred agents will only be approved for FDA and official compendium indications.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	CONCERTA (brand name methylphenidate ER) dexmethylphenidate (generic) FOCALIN XR (dexmethylphenidate ER) methylphenidate (generic RITALIN) methylphenidate SR (generic for Ritalin SR) STRATTERA (atomoxetine) VYVANSE (lisdexamfetamine)	DEXEDRINE (dextroamphetamine) FOCALIN (brand name dexmethyphenidate) INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) NUVIGIL (armodafinil) PROVIGIL (modafinil) RITALIN (brand name methylphenidate)	▪ Intuniv will be approved for clients with a diagnosis of ADHD and ADD ▪ Provigil will be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Multiple Sclerosis related fatigue or ADHD. ▪ Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. ▪ All other Non-preferred products will be approved for clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, or traumatic brain injury. **And** Non-preferred agents will only be approved for FDA approved age limitations. ▪ Provigil will be approved for clients 16 years of age and older. ▪ Nuvigil will be approved for clients 17 years of age and older. ▪ Adderall IR, Dexedrine and Dextrostat will be approved for clients 3 years of age and older. ▪ All other medications in this class will be approved for clients 6 years of age and older. **Daytrana and Methylin solution**: Clients with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications. **Intuniv**: Clients with ADD or ADHD will not need to fail on Preferred products if the client also has developmental delay. If a client does not have developmental delay, the client will need to fail on two preferred products. **Only one tablet per day will be approved.** **Nuvigil**: Clients will not need to fail on two preferred products if both of the following criteria are met: • they have tried and failed therapy on PROVIGIL; and • they meet the FDA approved indications and age limitation. **Only one tablet per day will be approved.** **Provigil**: Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation. **Only one tablet per day will be approved.** **Clonidine and guanfacine immediate release:** These products have been FDA approved for use in treating hypertension. They were not included in the class review and are not subject to Stimulant/ADHD criteria or restrictions.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
TARGETED IMMUNE MODULATORS FOR RHEUMATOID ARTHRITIS *Effective 1/1/2012*	**No Prior Authorization Required** ENBREL (etanercept) HUMIRA (adalimumab)	**Prior Authorization Required** CIMZIA (certolizumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous SIMPONI (golimumab) ***for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P**	**Cimzia** (all dosage forms) • will be approved for treatment of Crohn's disease in clients who have had treatment failure with Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) • will be approved for treatment of RA in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Kineret** will be approved for treatment of RA in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Orencia** will be approved for the treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Simponi** will be approved (in combination with methotrexate) for treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Simponi** will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction). **Grandfathering:** Clients currently stabilized on a Non-preferred product can receive approval to continue on that agent for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
TOPICAL IMMUNOMODULATORS *Effective 7/1/2011*	**No Prior Authorization Required*** ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	**Prior Authorization Required**	*No PA required for clients ages 2 years and older
TRIPTANS *Effective 1/1/2012*	**No Prior Authorization Required** IMITREX (brand) tablets, nasal spray and injection sumatriptan tablets MAXALT MLT tablets (rizatriptan)	**Prior Authorization Required** AXERT (almotriptan) AMERGE (naratriptan) FROVA (frovatriptan) RELPAX (eletriptan) TREXIMET (sumatriptan and naproxen) ZOMIG (zolmitriptan) Maxalt tablets (rizatriptan) sumatriptan nasal spray and injection	Non-preferred products will be approved for clients who have failed treatment with one Preferred Product within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Quantity Limits:** Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days. Maxalt: Max 12 tabs / 30 days. Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days. Imitrex injection: Max 4 injectors / 30 days